CAPITAL AREA PEDIATRICS

3937 Patient Care Dr. Ste. 101
Lansing MI 48911
517.394.6484 Fax: 517.394.7785

PATIENT INFORMATION

Patient's Legal Name: _____DOB:_____ () Male () Female

Home Address: _____City:_____State:____ZIP:_____

Patient Resides with Mother and Father () Yes () No **If no, please list**: _____

Parent/Guardian's information (please circle):

Legal Name: _____DOB:_____

Home Address: _____ity:_____State:____ ZIP:_____

Home Phone: _____Cell:_____Work:_____Ext:_____

Which phone number is the best number to reach you? ( ) Home ( ) Cell ( ) Work OK to leave a message? () Yes () No

Insurance Company Name:_____() Primary () Secondary

Parent/Guardian's Information (please circle):

Legal Name: _____DOB:_____

Home Address: _____ty:_____State:____ZIP:_____

Home Phone: _____Cell:_____Work:_____Ext:_____

Insurance Company Name :_____() Primary () Secondary

Information on Parent Child Does Not Live With (if applicable):

Legal Name: _____DOB:_____ () Male () Female

Home Address: _____City:_____State:____ZIP:_____

Home Phone: _____Cell:_____Work:_____Ext:_____

Which phone number is the best number to reach you? ( ) Home ( ) Cell ( ) Work OK to leave a message? () Yes () No

Insurance Company Name :_____() Primary () Secondary

Relationship to Child: () Father () Mother () Guardian () Other:_____

Medicaid Insurance Information:

Does the child have Medicaid Insurance? () Yes () No **If yes, Medicaid ID #:_____**

Emergency Contact (other than parents): Name: _____

Phone: _____ Relationship to Child: _____

I certify the above information is true and correct to the best of my knowledge:

Guarantor's signature: _____Date:_____

Guarantors relationship to the Child: () Father () Mother () Guardian () Other :_____

CAPITAL AREA PEDIATRICS HEALTH HISTORY (2 MONTHS –4 YEARS)

NAME	DATE OF BIRTH

PREGNANCY AND BIRTH HISTORY

What was this child's birth weight?_____ Length at birth _____

Did mother have any problems during the pregnancy? ☐No Problems ☐Illness requiring medication ☐Bleeding problem ☐High blood pressure ☐Sugar Diabetes ☐Premature Labor ☐Other _____

Was birth of child within 2 weeks of due date? ☐Yes ☐No

What type of delivery did the child have? ☐ Vaginal delivery ☐ C/Section delivery
Reason_____

Did child have problems in the newborn nursery ☐No problems ☐Yellow jaundice ☐Low blood sugar ☐Infection ☐Other_____
_____

Did child go home with mom from the hospital ☐yes ☐No

PAST MEDICAL HISTORY

Has your child ever been hospitalized overnight? ☐No ☐Yes
Reason_____
_____

Has your child had any surgery? ☐No ☐Yes Types of Surgery_____
_____

Has your child had any serious injury requiring medical attention ☐No ☐Yes Explain_____
_____

Has your child ever been diagnosed as having any of these problems? ☐Allergies ☐Asthma ☐Bladder/kidney infection ☐Chicken pox ☐Recurrent ear infection ☐Eczema ☐Hay fever ☐Heart problems ☐Pneumonia ☐Seizure ☐Recurrent sinusitis ☐Recurrent sore throat ☐Wheezing ☐Other medical problems_____

ALLERGIES/MEDICATIONS/IMMUNIZATION

Does your child have any allergy to medications? ☐No ☐Yes Explain_____

Is your child currently on any medications ☐No ☐Yes List all prescription medications that your child is on:
_____

Does your child receive a fluoride supplement? ☐Yes ☐No

Are your child's immunizations up to date? ☐Yes ☐No ☐I don't know (Please provide us with a copy of your child's immunizations)

TUBERCULOSIS RISK ASSESSMENT	NO	YES
Has your child ever had a positive TB skin test?		
Has any member of this child's family or anyone hat this child spends time with had a positive TB skin test or been treated for tuberculosis?		

EDUCATIONAL HISTORY

Has your child received services from Early On? ☐Yes ☐No
If yes, what is reason your child was referred?

Does your child attend a Headstart program or preschool? ☐Yes ☐No
If yes, do you or the teacher have any concern about how he is doing in this program ☐Yes ☐No

Please list any other information about your child that you would like us to know or any concerns you have at this time

_____
_____
_____
_____
_____

Parent or Guardian's signature	Date
Reviewed by provider	Date

Capital Area Pediatrics — Social History Form

Patient Name	Date of Birth
Mother's Name	Mother's Occupation

Mother's Education (Check any that apply)
☐ GED ☐ High School Diploma ☐ College graduate ☐ Some college/training ☐ Graduate School ☐ Post Graduate

Father's Name	Father's Occupation

Father's Education (Check any that apply)
☐ GED ☐ High School Diploma ☐ College graduate ☐ Some college/training ☐ Graduate School ☐ Post Graduate

Parent's Current Relationship
☐ Married ☐ Separated ☐ Divorced ☐ Living Together ☐ A couple but not Living together ☐ No longer together as a couple

If parents are not living in the same household, what is the custody arrangement?
☐ Lives with mom ☐ Lives with Dad ☐ Joint Custody ☐ Shared custody- weekends ☐ Shared custody-summers

Is the other parent involved?
☐ Father has regular visitation ☐ Mother has regular visitation ☐ Father not involved ☐ Mother not involved

List all people living in child's household

Name	DOB (MM/YY)	Relationship to child	Name	DOB (MM/YY)	Relationship to child

What is the current child care arrangement?
☐ Mother doesn't work outside the home ☐ Father doesn't work outside the home ☐ Parents work different hours
☐ Cared for by a relative ☐ Day Care Home ☐ Day care center ☐ Babysitter/ Nanny ☐ Other:_____

Have there been any recent stresses in the family?
☐ Parental job loss ☐ Parental job change ☐ Family move ☐ Major illness in family member ☐ Death in family
☐ Recent parental separation/divorce ☐ Loss of insurance ☐ Homeless/ Living in a shelter/ friend's house ☐ Other: _____

What is the child's race? Check those that apply
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ I don't wish to identify my child's race

What ethnicity is your child?
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I do not wish to identify my child's ethnicity

What is the Primary Language spoken in your home?
☐ English ☐ Hindi ☐ Spanish ☐ Other_____

What is the source of drinking water at the home where the child lives?
☐ Well water ☐ Bottled water ☐ Bottled water w/ fluoride ☐ Lansing city ☐ Other city:_____

Does anyone who lives in your house smoke?
☐ No one smokes at home ☐ Mother smokes in home ☐ Father smokes in home ☐ Family members smoke in home
☐ Mother smokes outdoors only ☐ Father smokes outdoors only ☐ Family members smoke outdoors only

For children 6 yrs or less to help us assess your child's risk of lead exposure, please check all that apply:
☐ Live in a house Built before 1950 ☐ Live in a house built between 1950 and 1978 ☐ Visits a house built before 1950 regularly ☐ Child has a playmate/ sibling that has been diagnosed w/ lead poisoning

Do you live in a house that has undergone major remodeling recently? ☐ Yes ☐ No

Parent/Guardian Signature: _____

Capital Area Pediatrics — Family History Form

Patient Name: _____ Date of Birth: _____

Does any biologic relative (Parents, Grandparents, Siblings, Aunt/Uncle) have any of the following health problems?

Please circle yes or no for each of the following health problems:		Name the family members that have the problem by listing their relation to the child
Respiratory or Allergies		
Asthma	Yes No	
Allergies	Yes No	
Allergic Rhinitis	Yes No	
Eczema	Yes No	
Other: _____		
Cardiovascular Diseases		
Heart disease in male family member before age 55	Yes No	
Heart disease in female family member before age 65	Yes No	
Sudden Unexpected Death	Yes No	
Heart Attack	Yes No	
Angina	Yes No	
Coronary Artery Disease	Yes No	
Stroke	Yes No	
Blood clots	Yes No	
High Blood Pressure	Yes No	
Arrhythmia	Yes No	
Other:_____		
Mental Health Concerns		
Depression	Yes No	
Attention Deficit Hyperactivity Disorder	Yes No	
Anxiety Disorder	Yes No	
Alcohol/Drug Abuse	Yes No	
Other:_____		
Inherited Disease		
Sickle Cell Trait	Yes No	
Sickle Cell Anemia	Yes No	
Hearing Loss	Yes No	
Birth Defect	Yes No	
Other Inherited Disease:_____ _____		
Miscellaneous		
Cancer	Yes No	
Seizure Disorder	Yes No	
Epilepsy	Yes No	
High Cholesterol	Yes No	
Diabetes	Yes No	
Problems with anesthesia	Yes No	

List any other health problems in your family that are not previously listed:_____ _____

Parent/ Guardian Signature	Date	Reviewed by Provider	Date

Capital Area Pediatrics
3937 Patient Care Drive, Suite 101
Lansing, Michigan 48911
(517) 394-6484 fax (517) 394-7785

Authorization for Disclosure of Protected Health Information

Patient Name_____ Birth Date_____

Address_____ Phone No._____

1. I authorize disclosure of the protected health information (child's name) _____ be made by:

Previous Practice Name: _____

Address _____

Phone _____ **Fax** _____

Information to be disclosed will include, as applicable, unless crossed out:

- Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.
- Information about human immunodeficiency virus-HIV acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC, as defined by Department of Community Health rules (1989 Public Act 174)

2. Person or organization authorized to receive information: **Capital Area Pediatrics**
3937 Patient Care Drive, Suite 101
Lansing, MI 48911

3. Specific Type of information to be disclosed.

☐ Entire Record ☐ Immunization Records ☐ Records from visit on_____

☐ Other_____

4. This information may be disclosed for the following purpose:

☐ Continued Care ☐ Personal Use ☐ Attorney Use ☐ Insurance Use

☐ Other_____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

6. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be disclosed and no longer protected by those laws and regulations

7. I understand that I may revoke this authorization at any time by notifying Capital Area Pediatrics in writing by sending a letter to the attention of the office manager. However, the revocation will not be valid if Capital Area Pediatrics has taken action in reliance on this authorization.

8. This authorization expires 365 days from date of the signature below unless otherwise requested.

_____ _____
Printed name of patient or patient's representative Relationship to child

_____ _____
Signature of patient or patient's representative Date

Capital Area Pediatrics has verified the identification of patient's representative

☐ Person known to staff ☐ driver's license/state identification ☐ other_____

Capital Area Pediatrics

Written Acknowledgment of
Patient Centered Medical Home Contract
Receipt of Notice of Privacy Practices
Receipt of Appointment Cancellation Policy

I have received a copy of Capital Area Pediatrics Medical Home Contract, Notice of Privacy Practices and Cancellation Policy.

I understand that if my child misses three appointments in a 12 month period, he/she and all other children in the household will no longer be able to receive medical care from Capital Area Pediatrics.

I, _____, acknowledge receipt of these policies on behalf of
Parent or Guardian

my child _____ whose date of birth is_____.
Patients name

Signature_____ Date_____
Parent or Guardian

Relationship to child_____

Capital Area Pediatrics, P.C.
Financial Policy

Thank you for choosing Capital Area Pediatrics. We strive to provide the best quality care for our patients and families. Please carefully read the following, initial, sign and return to our office. Please contact our office if you have any questions.

1. It is your responsibility to know your benefits prior to any visit. To avoid unexpected balances, you should contact your insurance company prior to the visit to ensure that you know your benefits and limitations. In addition, while most insurance companies cover well child visits (including vaccines, screening, counseling, etc) at no cost to you, your insurance plan may charge for additional procedures done during a well child visit. Furthermore, any additional health concerns discussed or addressed during a well child visit (outside of the growth and development of your child), your insurance company may consider these two separate visits and may apply a patient responsibility (depending on your benefits: copay, deductibles, co-insurances, etc.).
   Some examples of procedures that may have an out-of-pocket expense (but not limited to):
   - **Evening Appointments (appointments made at 5:00 pm or after)**
   - **Photo Vision Screen**
   - **Hearing Screen**
   - **In-House Labs**
   - **Umbilical Cord Chemical Cauterization**
   - **Wart Removal**
   - **Ear Wax Removal**
   - **Abscess Drainage**
   - **Telemedicine visits (video or phone)**
   - **Afterhours Phone Calls (On-Call or Other Parent-Initiated Calls)**
   - **Travel Consults/Travel Vaccines**
   - **Well Child Visits Combined with Other Non-Preventative Concerns (**Behavioral Questions, Asthma Questions, Non-Preventative Questions, Medication Refills, Referrals, Labs, Other Procedures, Etc**.)**
   - **Additional Time Spent Evaluating and Addressing Non-Preventative Concerns**
   - **Out-of-Network Services/Non-Covered Services**
   - **Care Management**

   Initials: _____

2. It is your responsibility to provide our office with your current insurance information. Currently, we are asking all parents/guardians to provide all insurance cards and photo identification to update our records. In addition, please informed our office of any changes, such as change in insurance, address, phone number, etc.
3. **Important! Our office does not bill based on court documents. The person (parent/guardian/other) who brings the child to the appointment is responsible for any charges from that visit, including copays and additional expenses.** If your insurance is inactive and you are considered "cash patient", payment is due at the date of visit/check-out. We are happy to accept  , cash, checks, and money orders. Payments can also be made by phone or through our Patient Portal.
4. Medicaid – We only accept Medicaid for established patients or if it is your secondary/tertiary insurance. We only participate with Straight Medicaid, Blue Cross Complete of Michigan, and McLaren Medicaid. If you have any other Medicaid Health Plan, your appointment may be cancelled, or you may have to pay out of pocket for visit.
5. **New Patients** – **We do not accept Medicaid or any Medicaid HMO as a primary insurance.** If your child converts to Medicaid as primary insurance within 90 days of their first visit they will be considered for discharge.
6. **Missed/No Show Appointment Policies**:
   - **Missed Appointment Policy** - If a scheduled appointment is missed, meaning cancelled with less than a 4-hour notice or you are more than 15 minutes late, it is considered a "Missed Appointment". Your family is allowed 3 Missed Appointments in a 12-month period and considered for discharged after the 3rd missed appointment.
   - **No Show Policy** - If you "No Show" for a scheduled appointment, meaning you did not call our office to let us know that you could not make the appointment, a **$20.00 fee** will be charged to your account.

   Initials: _____

7. Medical Records Fees (only for personal copies):
   - Paper: $35.00 Maximum ($1.00 per page)
   - Compact Disc: $25.00
8. Sports Physical Appointments: $30
9. Returned Check Fee: $40.00
10. FMLA Form Fee: $20.00
11. Other Form Fees: Amount charged is at the provider's discretion.

Failure to follow any of the above conditions may result in the discharge of your family.

Assignment of Benefits: For all services rendered by Capital Area Pediatrics, P.C. I authorize my insurance to issue all payments directly to them. **I** understand that I am responsible for any amounts not covered by my insurance.

I _____, parent of _____
have read, understand, and agree to this Financial Policy for all my children seen at Capital Area Pediatrics, P.C.:

Guarantor's Signature:
_____Date:_____

Guarantor's Relationship to the Child: () Father () Mother () Guardian ()
Other:_____

Portal Invite

Optional: Please provide your email address to send/receive secure messages from our Patient Portal:

_____

Office Use Only:

Pat#:	Pat#:	Pat#:
Pat Name:	Pat Name:	Pat Name:
Pat#:	Pat#:	Pat#:
Pat Name:	Pat Name:	Pat Name: